

SUBSTANCE OVERDOSE / POISONING / EXPOSURE TO TOXIC CHEMICALS

ACTION/TREATMENT:

- Ensure personal safety.
- Separate patient from causative agent.
 - Victim's clothing should be removed and isolated by personnel wearing proper personal protective equipment.

NOTES:

- **Decontamination may delay ALS interventions and must be guided by qualified personnel**
- **Victims should be decontaminated prior to transport whenever possible.**
- ABCs/monitor cardiac rhythm.
- Check pupil size.
- Spinal immobilization if indicated.
- IV access, rate titrated to perfusion as needed.

➤ **Suspected narcotic overdose:**

- ◆ Naloxone in patients with evidence of narcotic use and respirations $\leq 12/\text{min}$.
 - Titrate to an adequate respiratory rate/tidal volume, and a responsive patient without signs of withdrawal:
 - 0.8, 1 or 2 mg IM, may repeat once.
 - Alternative: 0.4-1 mg IVP, every 2-3 minutes prn. (May consider 4 mg ET once in selected cases.)
- ◆ **Pediatric Patients:**
 - Naloxone for suspected narcotic overdose.
 - Titrate to age appropriate respiratory rate (See I-20) and awake responsive patient without signs of withdrawal:
 - 0.1 mg/kg IM to a maximum dose of 1 mg, may repeat once.
 - 0.1 mg/kg IVP every 2-3 minutes as needed to maximum of 1 mg per dose.

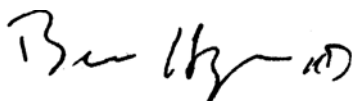
➤ **Suspected organophosphate poisoning:**

- ◆ **Atropine:**
 - 2-5 mg IVP or per BH. Repeat 1-2 mg IVP as needed
 - 2 mg IM, repeat as needed, if no IV or if Mark I kit used.
- ◆ **Pediatric Patients**
 - Atropine: 0.05 mg/kg IVP or BH order, minimum dose of 0.1 mg IVP

Shaded text indicates BH order

Unshaded text indicates standing order

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Treatment Guidelines:medical:M-50
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➤ **Suspected Tricyclic OD:**

- Hyperventilation if intubated.
- **NaHCO₃:** 1 mEq/kg IVP.

◆ **Pediatric Patients:**

- **NaHCO₃** 1 mEq/kg IVP.

➤ **Suspected CO poisoning:**

- 100% high flow oxygen via non-rebreather mask.
- Consider PRC with hyperbaric chamber for selected symptoms:
 - Coma
 - Severe neurologic deficits secondary to exposure

➤ **Suspected extrapyramidal reaction:**

- **Diphenhydramine:** 25-50 mg IVP or deep IM
- ◆ **Pediatric Patients:**
 - **Diphenhydramine:** 1 mg/kg IVP or deep IM.

➤ **Suspected nerve agent exposure:**

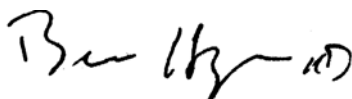
- **Mild/Moderate Symptoms:**
 - ◆ **Mark I kits (Atropine 2 mg auto-injector and pralidoxime 600 mg auto-injector)**
 - 1-2 Mark I kits, IM at 10 minute intervals. Maximum 3 Mark I kits.
 - ◆ **If Mark I kits not available:**
 - **Atropine:** 2-4 mg IM/IV at 10 minute intervals as needed.
- **Severe Symptoms:**
 - ◆ **Mark I kits (Atropine 2 mg auto-injector and pralidoxime 600 mg auto-injector)**
 - 3 Mark I kits, IM in rapid succession.
 - ◆ **If Mark I kits not available:**
 - **Atropine:** 6 mg IM/IV repeat as needed.
- **Elderly Patients (> 65 years of age) or those with underlying cardiovascular or renal disease:**
 - **Atropine:** 1.0 mg IM. Repeat doses may be given at base direction; IM or IV
 - **Pralidoxime (2-PAM, Protopam):** 7.5 mg/kg IM, maximum of 600 mg (one auto-injector) per dose.

Note: Elderly patients must weigh at least 80 kg to receive 1 auto-injector of pralidoxime IM.

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➤ Suspected nerve agent exposure (continued):

➤ Pediatric Patients (< 12 years):

- Atropine
 - 0-2 years: 0.5 mg IM.
 - ≥2-12 years: 1.0 mg IM.
 - 0.02 mg/kg IVP, minimum of 0.1 mg IVP
- Pralidoxime (2-PAM, Protopam):
 - 20 mg/kg IM or IVP.

Note: Pediatric patients must weigh at least 30 kg to receive 1 auto-injector IM.

Notes:

- If pralidoxime (2-PAM, Protopam) powder 1 Gm for reconstitution is available: Reconstitute as directed by Base Hospital or use 20 mL sterile water without preservative to produce a concentration of 50 mg/mL.
- ♦ **Adult Patients:** 1 Gm over 30 minutes IV or 600 mg-1 Gm IM in divided injections if necessary.
- ♦ **Elderly Patients:** 7.5 mg/kg IM or IV. Maximum IV dose is 1 Gm over 30 minutes. May repeat once in one hour.
- ♦ **Pediatric Patients:** 20 mg/kg IM or IV. Maximum IV dose is 1 Gm over 30 minutes. May repeat once in one hour.
 - Use auto-injectors for initial atropine doses if Mark I kit used.
 - If hypoxia is present, give first dose atropine IM.
 - Adjust atropine dose to respiratory secretions and ease of ventilation.
 - The elderly require less atropine and pralidoxime.
 - Midazolam (or diazepam auto-injector) may be used cautiously if seizures are not controlled by atropine.

➤ Suspected cyanide intoxication:

- Conscious victims do not need field antidotes; high flow oxygen is sufficient.
 - 100% high flow oxygen via non-rebreather mask if possible.
 - ❖ Mouth-to-mouth and mouth-to-device ventilation is contraindicated due to potential for secondary contamination. Use only mechanical devices.
- Unconscious victims, or those who are or severely affected (e.g., severe dyspnea, severe hypotension):
 - Sodium Thiosulfate 25%, 50 mL (12.5 gm) IVP
- Pediatric patients:
 - Sodium Thiosulfate 25%, 1.6 mL/kg IVP.

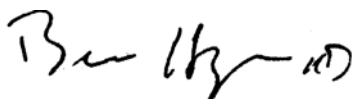
Notes:

- Monitor possible stimulant users for hyperthermia.
- Antidotes may be ordered at BH physician discretion.

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